

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001897

FILED VS FEB 15 1960

149

Registration District No. Primary Registration District No. Registrar's No.

584

STATE FILE NUMBER

DEED

| | | | | | | | | |
|---|---|---|---|--|--|---|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Jackson</i> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Jackson</i> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i> | | Length of stay in lb <i>57 yrs.</i> | | c. CITY OR TOWN <i>Kansas City</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>General Hosp.</i> | | | | d. STREET ADDRESS (If outside, give location) <i>5826 E 15th St</i> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <i>Mertie</i> Middle <i>Olive</i> Last <i>Smith</i> | | | | 4. DATE OF DEATH Month <i>1</i> Day <i>29</i> Year <i>60</i> | | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <i>1/5/1866</i> | 9. AGE (last birthday) <i>94</i> | IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> | IF UNDER 24 HR Hours <i>0</i> Min. <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>--</i> | | 11. BIRTHPLACE (City and state or country) <i>Unknown</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i> | |
| 13a. FATHER'S NAME <i>Jeffry W. Randall</i> | | | 13b. MOTHER'S MAIDEN NAME <i>Adline May</i> | | | 14. NAME OF HUSBAND OR WIFE <i>Charles W. Smith</i> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i> | | | 16. SOCIAL SECURITY NO. <i>none</i> | | 17. INFORMANT <i>Mrs. J. J. Weir</i> | | | Address <i>Bates City, Mo.</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Px. Left hip</i> | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>Patient fell outside her home</i> | | | | | | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year <i>1-18-60</i> | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <i>Outside home</i> | | | | | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Outside home</i> | | 20f. CITY, TOWN, OR LOCATION <i>Kansas City</i> | | COUNTY <i>Missouri</i> | | STATE <i>Missouri</i> | | |
| 21. I attended the deceased from <i>1-18-1960</i> to <i>1-29-1960</i> and last saw her alive on <i>1-19-1960</i> Death occurred at <i>2:25 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Typed or title) <i>Charles B. Wheeler MD</i> | | | | 22b. ADDRESS <i>2400 Perry City</i> | | 22c. DATE SIGNED <i>1/29/1960</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | | 23b. DATE <i>Feb. 1, 1960</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Washington Ceme.</i> | | 23d. LOCATION (City, town, or county) <i>Kansas City, Missouri</i> | | | |
| 24. FUNERAL DIRECTOR <i>Earp & Sons 4707 Truman Rd. K.C. Mo</i> | | | | 25. DATE RECD. BY LOCAL REG. <i>2-1-60</i> | | 26. REGISTRAR'S SIGNATURE <i>Wesley Marshall</i> | | |

DOCUMENT

Charles B. Wheeler
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William H. Cary

Licensed Embalmer No. 472

P. O. Address N. C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.